I	EPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES									
ſ	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY					
ı	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	00	COMPLETED					

AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER: 155620	A. BUII B. WIN	LDING G	00	COMI 12/07/	PLETED 2011		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN46077						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PERCEDED BY FULL		(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
F0000	Complaint IN00 Federal/State de allegation are cir F412. Survey Date: D Facility Numbe Provider Numbe AIM Number: Survey Team: Linda Campbel: Census Bed Typ SNF/NF: SNF: 16 Residential: Total: 229 Census Payor T Medicare: 25 Medicaid: 102 Other: 102 Total: 229 Sample: 3	0100359 - Substantiated. eficiencies related to the lited at F250, F411 and December 7, 2011 r: 000538 er: 155620 100267290 1, RN pe: 142 71 9 Type: 22	FO	0000					

 $LABORATORY\ DIRECTOR'S\ OR\ PROVIDER/SUPPLIER\ REPRESENTATIVE'S\ SIGNATURE$

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KWS211

Facility ID:

000538

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/07/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN46077				
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F0250 SS=D	Quality review 1. Williams, RN The facility must p social services to a highest practicable psychosocial well-Based on intervie facility failed to social services w related to obtaining for 2 of 3 resident in a sample of 3. Findings include 1. Resident # C's reviewed on 12/7 record indicated with diagnoses w not limited to, to internal carotid, oneuropathy, and a A Minimum Data assessment dated resident was cognoccasional mode.	s clinical record was 1/11 at 9:50 A.M. The the resident was admitted which included, but were tal occlusion of the right obesity, rhinitis, dementia. a Set (MDS) quarterly 11/11/11 indicated the intively intact, had rate pain, and had mouth scomfort or difficulty	F0	250	F 250 Provision of Medicall Related Social Service It is the practice of this provious provide medically-related social services to attain or maintain highest practicable physical, mental, and psychosocial well-being of each resident. What corrective actions(s) well-being of each resident for those residents found to have been affected by the deficient practice? Resident # C had tooth extractions on 11/16/11 and its scheduled to see the oral sur (per their recommendation) of 1/11/2012 for follow-up. The resident is assessed for tooth pain daily and has required provided in the pain daily and has required provided for tooth pain. The pain been effectively relieved with acetaminophen. The resider receive follow-up dental serv as needed, the attending physician is notified of a charm in the resident's condition, as in the resident's condition, as	der to cial the will en en east en has en	12/21/2011

JMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			IULTIPLE CO ILDING	00 CON		TE SURVEY MPLETED 7/2011	
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	8/29/11 at 12:27 outside dentist a complete due to their chairs. Has dental list per St. 8/31/11 at 8:37 having a tooth a (company name placed on list for A dental schedu indicated the rest to see a dentist of and thirteen day tooth ache). Nurses' notes in 9/28/11 at 9:32 to see dentist. S director) had rest faxed to dentist seen next visit." 10/7/11 at 3:02 next week for counable to be see dentist"	alle for the facility dentist sident had been scheduled on 10/12/11 (one month is after complaining of a dicated: A.M. "Resident requested SD (social services sident sign consent form, and added to list to be		TAG	needed. Resident # A had a fol appointment with the of 12/15/11 but the appointments. The second appointments appointments are sident's dental status assessed daily and the physician is notified of in the resident's conditioneded. How will you identify residents having the to be affected by the deficient practice and corrective action will. Residents with dental have the potential to be by the alleged deficient. An audit was completed be partment Heads on to ensure that current dental needs are addressively. Results were provided to the services for appropriation of the services for residents and emergent basis. The has added additional corrections are addressively as a services. Care/Concern forms are as nursing stations for residents.	dentist on intment was possible ting future. The sis eattending a change tion, as other potential same di what be taken? problems eaffected at practice. The deat provided to reseate and up dental on a routine. The facility dental ept all payer vailable at the	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			ĺ	ULTIPLE COI LDING	NSTRUCTION 00	COMPI	ETED
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	PROVIDER OR SUPPLIER			675 S F	.ddress, city, state, zip code ORD RD /ILLE, IN46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	tooth. States low A "Dental Treatr	ibiotic for impacted er jaw/tooth pain." nent Plan" dated ed "Pt (patient) was			responsible parties to utilize to communicate resident needs. The reviewed by the Executive Directed designee for appropriate follow-utility. What measures will be put place or what systemic	or, or p.	
	scheduled for the initial oral exam (examination), but it was an emergency exam. Pt complained of pain, PA & T (x-rays) taken, infection observable swelling, will refer to an OS (oral surgeon) to take a pano (panoramic) radiograph to determine which teeth need to be removedAntibiotics Rx (treatment) per MD approval"				changes you will make to ensure that the deficient practice does not recur?		
					Residents and/or responsib parties were notified by letter ancillary providers, as well a means to communicate residenceds to the facility utilizing Care/Concern Forms, notify Social Service, notifying nurand/or the Executive Directors.	er, of as the dent ring rsing,	
	indicated "Kefler (milligrams) PO (capsule) TID (th	der dated 10/13/11 x (an antibiotic) 500 mg (by mouth) i (one) cap aree times a day) x e: impacted tooth."			Resident change of condition including dental and oral problems, are communicated the charge nurse by utilizing 24 Hour Report and notificate their respective nurse management of the Interdisciplinary Team	ed by g the tion to	
	Nurses' notes indicated the resident complained of tooth pain and was given pain medication on 10/14/11, 10/15/11, 10/16/11, 10/17/11, 10/18/11, 10/19/11, 10/20/11, and 10/21/11. The resident was given another course of Keflex on 11/14/11.				reviews the 24 Hour Report during regular business day the nurse manager on-call i notified of resident change condition on weekends and holidays. Referrals to Social Service or dental services a completed, as needed.	rs and s of	
	oral surgeon and with recommend	seen on 11/16/11 by an had three teeth extracted ation of having tions in the future.			Resident oral cavity is asse during a resident assessme completed weekly by the resident's charge nurse. Abnormal findings are report the attending physician,	nt	

		ľ í		JLTIPLE CON	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF O	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155620	B. WIN			12/07/2011	
NAME OF PROV	VIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					ORD RD		
	E MEADOWS			<u> </u>	'ILLE, IN46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION) 7/11 of 10:27 A.M. with	+	TAG	responsible party, and social	DATE	
		7/11 at 10:37 A.M. with			service for follow-up.		
	_	indicated residents with					
		other than routine			Social Service employees we	ere	
		ould be "seen right away."			re-educated on providing	200	
		referrals to outside			medically-related social servi for the residents on 12/8/11,		
Services Directo		ty) dentists the Social			the Executive Director.		
de	entist and made	appointments.			Nursing employees were	ntol	
		1 0 /44			re-educated on assessing de needs and notification of	riitai	
		17/11 at 11:50 A.M. with			physician, responsible party,		
		es Director indicated			social service and nursing		
		ontacts the providers for			supervisor, by Director of Nu	rsing	
	• •	d can usually "get them in			Services, or designee, by		
	-	licated "few providers			12/20/11, with a post-test.		
	-	caid." He indicated			The Interdisciplinary Team,		
		111 was the "next			including Social Service, was	;	
	• •	ment" and "the pain was			re-educated on the Clinical		
		y nursing staff." He			Meeting Guidelines as it relat		
in	ndicated there w	as no documentation			reviewing the 24 Hour Repor resident change of condition,		
re	elated to dates at	ttempts were made to			the Director of Nursing Service		
ol	btain dental app	ointments. He stated "I			on 12/19/11.		
l ju	ıst made a phone	e call." He indicated the			Oleff		
_	-	olicies or procedures			Staff were re-educated on the Care/Concern forms that may		
		g appointments with			utilized by residents and	,	
	utside dental ser	• • •			responsible parties to notify t		
					facility of dental concerns, by	,	
Ir	nterview on 12/7	7/11 at 11:45 A.M. with			Director of Nursing Services,		
		r indicated residents with			designee, by 12/20/11, with a post-test.	2	
	urgent dental concerns should be seen "within 7 days I would think."				poor toot.		
					Staff were re-educated on the	9	
					provision of timely ancillary	_	
1,	. Resident #A's	clinical record was			services as arranged by Soci Service, on 12/20/11, by Dire		
		7/11 at 10:20 A.M. The			of Nursing Services, with a	,0101	
		the resident was admitted			post-test.		
<u> </u>	(02-99) Previous Version		I KWS211	Facility II	D: 000538 If continuation sh	leet Page 5 of 18	

F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COME	COMPLETED 12/07/2011	
LE MEADOWS		675 S ZIONS	FORD RD	RD RD		
(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION :	SHOULD BE	(X5) COMPLETION DATE	
with diagnoses on the limited to, do and moderate/set (inflammation of the limited to, do and moderate/set (inflammation of the limited to, do and moderate/set (inflammation of the limited the responsibility of the limited the responsibility of the limited the responsibility of the limited the limited the limited the responsibility of the limited the l	which included, but were ementia, prostate cancer, evere peridontitis of the gums). Ita Set (MDS) significant ent dated 9/27/11 eident was severely eaired, had a poor appetite, led pain medication dono dental problems. Ider dated 10/26/11 eigel (sic) (an expected representation of the properties o		The facility has addedental providers that all payer sources. Social Service is resensuring resident roemergent dental need through review at the Interdisciplinary meed follow-up through the process. How will the correct action(s) be monitodensure the deficien will not recur, i.e., vassurance programminto place? A Dental Services Cutilized weekly x 4, a 2 and quarterly x 2, Service/Nursing Manmonitor compliance physician notification will be reviewed by the committee and action be developed, if a the 90% is not achieved compliance. Nonconfacility policy and proresult in employee eand/or disciplinary a and including terminal	sponsible for utine and eds are met e daily eting with e CQI stive ored to the practice what quality in will be put and monthly x by Social magers to with in. The audits the CQI on plans will inceshold of late to improve mpliance with ocedure may education ction up to nation.		
	SUMMARY S (EACH DEFICIEN REGULATORY OF with diagnoses was not limited to, do and moderate/se (inflammation of A Minimum Date change assessme indicated the rest cognitively imparts was on a scheduregimen, and had a physician's or indicated "Ora over-the-counter tooth and gump (every shift) & C (as needed) x 7 c	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) with diagnoses which included, but were not limited to, dementia, prostate cancer, and moderate/severe peridontitis (inflammation of the gums). A Minimum Data Set (MDS) significant change assessment dated 9/27/11 indicated the resident was severely cognitively impaired, had a poor appetite, was on a scheduled pain medication regimen, and had no dental problems. A physician's order dated 10/26/11 indicated "Oragel (sic) (an over-the-counter topical medication for tooth and gum pain) - apply to gum QS (every shift) & Q40 (every four hours) prn (as needed) x 7 days." Nurses' notes indicated the resident had bleeding of the gums on 10/28/11, 10/30/11, 11/6/11, 11/17/11, 11/18/11, 11/9/11, 11/20/11, and 11/21/11. On 11/15/11 at 2:09 P.M. "Family and social service are working on getting resident in to see a dentist for evaluation and treatment" A social service note dated 11/22/11 at 3:34 P.M. indicated "Spoke with resident daughter this afternoon. Resident has dental appointment tomarrow (sic)	TOWIDER OR SUPPLIER LE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) with diagnoses which included, but were not limited to, dementia, prostate cancer, and moderate/severe peridontitis (inflammation of the gums). A Minimum Data Set (MDS) significant change assessment dated 9/27/11 indicated the resident was severely cognitively impaired, had a poor appetite, was on a scheduled pain medication regimen, and had no dental problems. A physician's order dated 10/26/11 indicated "Oragel (sic) (an over-the-counter topical medication for tooth and gum pain) - apply to gum QS (every shift) & Q40 (every four hours) prn (as needed) x 7 days." Nurses' notes indicated the resident had bleeding of the gums on 10/28/11, 10/30/11, 11/6/11, 11/17/11, 11/18/11, 11/9/11, 11/20/11, and 11/21/11. On 11/15/11 at 2:09 P.M. "Family and social service are working on getting resident in to see a dentist for evaluation and treatment" A social service note dated 11/22/11 at 3:34 P.M. indicated "Spoke with resident daughter this afternoon. Resident has dental appointment tomarrow (sic)	FORRECTION IDENTIFICATION NUMBER: 155620 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CREATING TO CHARLES ALL OF THE LEAST CONCESS PLEATED TO THE LEAST CONCESS PLANTED TO THE LEAST	Dentification Number: 155620 Building 3 Wing	

DENTIFICATION NUMBER: 156620 12/07/2011 12/07/201	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
STREET ADDRESS, CITY, STATE, ZIP CODE 676 S FORD RD ZIONSVILLE MEADOWS (X4) D SUMMARY STATEMENT OF DEFICIENCIES PRIFIT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The resident was seen by a dentist on 11/23/11 (28 days after Oragel for the gums was ordered). A dental visit note dated 11/23/11 indicated "Patient (resident #A name) was seen in our office on November 23, 2011, for an oral examination and periodontal debridement. Patient was diagnosed with moderate/severe periodontilis" Interview on 12/7/11 at 11:50 A.M. with the Social Services Director indicated he had been on medical leave until October 10, 2011. When he returned he was unaware the resident had been done prior to his return. He indicated he had spoken with the residents daughter and told her "we would get him into a dentist." He indicated he could usually get appointments in "1-2 days." Interview on 12/7/11 at 11:45 A.M. with the Administrator indicated residents with urgent dental concerns should be seen "within 7 days I would think." This federal tag relates to complaint IN00100359.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
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IN00100359.								
IN00100359.		This federal tag	relates to complaint					
		_	F					
3.1-34(a)								
		3.1-34(a)						

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	A. BUII B. WIN	LDING	00	COMPLETED 12/07/2011		
	OVIDER OR SUPPLIER LE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN46077					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
SS=D	A facility must provoutside resource, i §483.75(h) of this emergency dental of each resident; no resident an addition emergency dental necessary, assist that appointments; and transportation to an and promptly refer damaged dentures. Based on record a facility failed to a resident with bluresidents with desample of 3. (Resident #A's clinareviewed on 12/7 record indicated the with diagnoses where the sample of the sampl	part, routine and services to meet the needs hay charge a Medicare nal amount for routine and services; must if the resident in making by arranging for and from the dentist's office; residents with lost or to a dentist. The review and interview, the obtain dental services for eeding gums for 1 of 3 antal problems in a sident #A). In the resident was admitted thich included, but were mentia, prostate cancer, were peridontitis of the gums). A Set (MDS) significant	F0	411	F 411 Routine/Emergency Dental Services in SNFs It the practice of this provider to provide or obtain from an out source, in accordance with 483.75(h) of this part, routine emergency dental services to meet the needs of each resid may charge a Medicare resid an additional amount for rout and emergency dental service must if necessary, assist the resident in making appointme and by arranging for transportation to and from the dentist's office; and promptly resident with lost or damaged dentures to a dentist. What corrective actions(s) will be accomplished for those residents found to have be affected by the deficient practice? Resident # A had	side e and dent; dent ine ees; ents; e	12/21/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLE	TED
		155620	B. WIN			12/07/20	11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ORD RD		
ZIONSVI	LLE MEADOWS				/ILLE, IN46077		
					, III		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	cognitively impa	aired, had a poor appetite,			follow-up appointment with the	ne	
	was on a schedu	led pain medication			dentist on 12/15/11 but the appointment was cancelled to	ov the	
	regimen, and had	d no dental problems.			responsible party, who is	Jy IIIe	
		-			coordinating future dental		
	A physician's or	der dated 10/26/11			appointments. The resident	s	
	indicated "Ora				dental status is assessed da	ily	
		topical medication for			and the attending physician		
		*			notified of any change in the		
		ain) - apply to gum QS			resident's condition, as need	led.	
	(every shift) & Q40 (every four hours) prn				How will you identify other	.:al	
(as needed) x 7 days."				residents having the potent to be affected by the same	liai		
	Nurses' notes indicated:				deficient practice and what		
					corrective action will be take		
					Residents with dental probl	I .	
	10/28/11 at 10:3	5 P.M. "Orajel applied to			have the potential to be affect		
		ght upper gum noted			by the alleged deficient prac	tice.	
	_	mount of bleeding noted			An audit was completed by		
		-			Department Heads on 12/20		
		when slight pressure			to ensure that current reside	nts	
		currently awaitng (sic) apt			dental needs are addressed timely. Results were provide	ad to	
	(appointment) fr	om dental provider"			Social Service and Nurse	,	
					Managers for appropriate an	d	
	10/30/11 at 2:38	A.M. "Scant bleeding			timely follow-up. Social Ser		
	occurs when giv	en oral care q (every)			will set up dental services for	r	
	shift"				residents on a routine and		
					emergent basis. The facility		
	11/6/11 at 3:07	A.M. "small amount of			added additional dental prov that will accept all payer sou		
	bleeding of the				Care/Concern forms are	ices.	
	biccuring of the g	54111			available at the nursing station	ons	
	11/15/11 40.00	DM II Famil 1			for residents and/or responsi		
		P.M. "Family and			parties to utilize to communi		
		e working on getting			resident needs. They are		
	resident in to see a dentist for evaluation and treatment" Nurses' notes indicated the resident had				reviewed by the Executive		
					Director, or designee for	,	
					appropriate follow-up. Wha		
					measures will be put into p or what systemic changes		
		ne gums on 11/17/11,			or what systemic changes	you	
	i i i i i i i i i i i i i i i i i i i	0					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			OOMPLE 12/07/20				
			P. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	S.			ORD RD		
ZIONSV	ILLE MEADOWS			ZIONSV	/ILLE, IN46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
	· ·	11, 11/20/11, and			will make to ensure that the deficient practice does not		
	11/21/11.				recur?Residents and/or		
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			responsible parties were not	ified	
		note dated 11/22/11 at			of ancillary providers by lette	er, as	
		ted "Spoke with resident			well as the means to communicate resident needs	. 40	
	_	ernoon. Resident has			the facility utilizing Care/Con		
	* *	ent tomarrow (sic)			Forms, notifying Social Serv		
		conversation, assured			notifying nursing, and/or the		
	_	t would be assisted by			Executive Director. Resider		
	two aides at appointment for transfers"				oral cavity is assessed durin resident assessment comple		
				weekly by the resident's cha			
	The resident was seen by a dentist on				nurse. Abnormal findings ar	•	
	11/23/11 (28 day	s after Orajel for the			reported to the attending		
	gums was ordere	ed).			physician and nurse manage	er for	
					follow-up. Need for dental appointment and/or follow-up	n ie	
	A dental visit no	te dated 11/23/11			referred to Social Services.	J 13	
	indicated "Patier	nt (resident #A name) was			Residents with dental conce	rns	
	seen in our office	e on November 23, 2011,			are placed on pertinent char		
	for an oral exam	ination and periodontal			to monitor for pain, problems chewing, etc. Resident cha		
	debridement. Par	tient was diagnosed with			of condition, including dental		
	moderate/severe	periodontitis"			oral problems, are communication		
					by the charge nurse by utiliz	ing	
	Interview on 12/	7/11 at 11:50 A.M. with			the 24 Hour Report and	_	
	the Social Service	es Director indicated he			notification to their respective nurse manager. The	.	
	had been on med	lical leave until October			Interdisciplinary Team review	vs	
	10, 2011. When	he returned he was			the 24 Hour Reports during		
	· ·	dent needed dental care			regular business days and the		
	and no followup	regarding obtaining			nurse manager on-call is not of resident change of conditi		
	-	ne resident had been done			weekends and holidays.	OII OII	
	prior to his return. He indicated he had				Referrals to Social Service for	or	
	-	resident's daughter and			dental services are complete	ed, as	
	told her "we would get him into a dentist." He indicated he could usually get				needed. Social Service employees were re-educated	d on	
					providing medically-related s		
	appointments in	, ,			services for the residents on		

000538

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		155620	B. WIN			12/07/2	UTT
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
71011011					ORD RD		
ZIONSVI	LLE MEADOWS			ZIONSV	/ILLE, IN46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	Interview on 12/the Administrato urgent dental cor "within 7 days Is Review on 12/7/facility policy an provided by the lidentified as curr Services" indicat maintains an out dental services to resident"	7/11 at 11:45 A.M. with or indicated residents with accerns should be seen			12/8/11, by the Executive Director. Nursing employee were re-educated on assessi dental needs, and notification physician, responsible party, social service and nursing supervisor, by Director of Nu Services, or designee, by 12/20/11, with a post-test. Licensed nurses were re-educated on assessment pain for interviewable and non-interviewable resident by Director of Nursing Services, designee, by 12/20/11, with a post-test. The Interdisciplina Team was re-educated on th Clinical Meeting Guidelines a relates to reviewing the 24 H Report for resident change o condition, by the Director of Nursing Services on 12/19/1 Staff were re-educated on th Care/Concern forms that ma utilized by residents and responsible parties to notify t facility of dental concerns, by Social Service or designee, t 12/20/11, with a post-test. S were re-educated on the provision of timely ancillary services as arranged by Soc Service, on 12/20/11, by Dire of Nursing Services, with a p test. Social Service are responsible for ensuring resir routine and emergent dental needs are met through review the daily Interdisciplinary me	s ing of of rsing of y the or a ary e as it our f 1. e y be the y be staff dector ost dent w at eting	
					with follow-up through the Coprocess. How will the corrective action(s) be		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 12/07/2011			
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
F0412 SS=G	from an outside re §483.75(h) of this covered under the emergency dental of each resident; n the resident in mal arranging for trans dentist's office; and residents with lost dentist.	y must provide or obtain source, in accordance with part, routine (to the extent State plan); and services to meet the needs nust, if necessary, assist king appointments; and by sportation to and from the d must promptly refer or damaged dentures to a action, interview, and	F0412	monitored to ensure the deficient practice will not rie., what quality assurance program will be put into place? A Dental Services tool will be utilized weekly x and monthly x 2 and quarter by Social Service/Nursing Managers to monitor complimith physician notification. audits will be reviewed by the committee and action plans be developed, if a threshold 90% is not achieve, to imprecompliance. Noncompliance facility policy and procedure result in employee education and/or disciplinary action up and including termination. Completion D 12/21/11	cQl 4, rly x 2, siance The ne CQl will of ove e with e may n			
	record review, the provide dental see resident's needs resulting in pain	refacility failed to revices to meet a related to impacted teeth and infection for 1 of 3 related problems in a		Routine/Emergen Dental Services in NFS This provider must provide obtain from an outside reson in accordance with 483.75(h	n e or urce,			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	л ріп	A. BUILDING 00		COMPLE	TED
		155620	B. WIN	12/0		12/07/20	11
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ORD RD		
ZIONSVILLE MEADOWS					/ILLE, IN46077		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	Findings include:				this part, routine (to the exte		
					covered under the State pla		
	On 12/7/11 at 10):35 A.M., with Unit			and emergency dental servi meet the needs of each resi		
		#1, Resident # C was			must, if necessary, assist th		
		n bed. The inside of the			resident in making appointm		
	1	was observed. There			and by arranging for		
		ctions with sutures on the			transportation to and from the	ne	
					dentist's office; and must		
		f the mouth. The resident			promptly refer residents with		
	indicated the are	a was "sore."			or damaged dentures to a d		
					What corrective actions(s be accomplished for those		
	Resident # C's clinical record was reviewed on 12/7/11 at 9:50 A.M. The record indicated the resident was admitted with diagnoses which included, but were				residents found to have be		
					affected by the deficient		
					practice? Resident # C ha	d	
					tooth extractions on 11/16/1		
	1	otal occlusion of the right			is scheduled to see the oral		
	internal carotid,	•			surgeon (per their		
	neuropathy, and				recommendation) on 1/11/2		
	incuropatity, and	dementia.			for follow-up. The resident in assessed for tooth pain dail		
	A Minimum Dad	to Cot (MDC) assessments			has required pain medicatio		
		ta Set (MDS) quarterly			time in the past week for too		
		d 11/11/11 indicated the			pain. The pain has been		
		gnitively intact, had			effectively relieved with prn		
		erate pain, and had mouth			acetaminophen. The reside		
	or facial pain, di	scomfort or difficulty			receive follow-up dental ser	vices,	
	with chewing.				as needed, the attending physician is notified of a cha	_{inge}	
					in the resident's condition, a	-	
	Nurses' notes indicated:				needed. How will you ide		
					other residents having the		
	8/29/11 at 12:27 P.M. "Has been seen per outside dentist and they were unable to complete due to inability to transfer to their chairs. Has been placed on facility				potential to be affected by		
					same deficient practice an		
					what corrective action will		
					taken? Residents with too pain have the potential to be		
		1			affected by the alleged defic		
	dentai fist per SS	S (social services)"			practice. An audit was		
					completed by Department F	eads	
	8/31/11 at 8:37 A.M. "Resident has been				· · ·		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 12/07/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE on 12/20/11, to ensure that having a tooth ache. Faxed consent to current residents' dental needs (company name) this morning to be are addressed timely. Results placed on list for next visit..." were provided to Social Service and Nurse Managers for appropriate and timely follow-up. A dental schedule for the facility dentist Social Service will set up dental indicated the resident had been scheduled services for residents on a routine to see a dentist on 10/12/11 (one month and emergent basis. The facility and thirteen days after complaining of a has added additional dental tooth ache). providers that will accept all paver sources. Care/Concern forms are available at the nursing Nurses' notes indicated: stations for residents and/or responsible parties to utilize to 9/28/11 at 9:32 A.M. "Resident requested communicate resident needs. They are reviewed by the to see dentist. SSD (social services Executive Director, or designee director) had resident sign consent form, for appropriate follow-up. What faxed to dentist and added to list to be measures will be put into place seen next visit." or what systemic changes you will make to ensure that the deficient practice does not 10/7/11 at 3:02 P.M. "...To see dentist this recur? Residents and/or next week for complaints of tooth ache responsible parties were notified unable to be seen when went out to of ancillary providers by letter, as dentist " well as the means to communicate resident needs to the facility utilizing Care/Concern 10/13/11 at 4:57 P.M. "Writer spoke with Forms, notifying Social Service, oral surgeon regarding making apt notifying nursing, and/or the (appointment) for tooth extraction. Order Executive Director. Resident oral cavity is assessed during a noted to start antibiotic for impacted resident assessment completed tooth. States lower jaw/tooth pain." weekly by the resident's charge nurse. Abnormal findings are A "Dental Treatment Plan" dated reported to the attending physician and nurse manager for 10/12/11 indicated "Pt (patient) was follow-up. Residents with dental scheduled for the initial oral exam concerns are placed on pertinent (examination), but it was an emergency charting to monitor for pain, exam. Pt complained of pain, PA & T problems with chewing, etc.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f '		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00		00		
		155620	B. WIN	IG		12/07/201	1
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NUMBER OF THE VIBER OR SOFT ELER					ORD RD		
ZIONSVILLE MEADOWS				ZIONSV	/ILLE, IN46077		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	1 \ 2 /	nfection observable			Resident change of condition	١,	
	swelling, will ref	fer to an OS (oral		including dental and oral problems, are communicated by the charge nurse by utilizing the			
	surgeon) to take	a pano (panoramic)					
	radiograph to de	termine which teeth need			24 Hour Report and notificati		
	to be removed	Antibiotics Rx			their respective nurse manag		
	(treatment) per N	AD approval "			The Interdisciplinary Team		
	(droudingin) per in	12 upprovum			reviews the 24 Hour Reports		
	A physician's or	der dated 10/13/11			during regular business days		
					the nurse manager on-call is notified of resident change of		
		x (an antibiotic) 500 mg			condition on weekends and	'	
		(by mouth) i (one) cap			holidays. Referrals to Social		
	(capsule) TID (three times a day) x (times) 7 daysre: impacted tooth." Nurses' notes indicated: 10/14/11 at 3:13 A.M. "Resident c/o				Service for dental services a		
			completed, as needed. Social				
					Service employees were		
					re-educated on providing		
					medically-related social servi		
					for the residents on 12/8/11, the Executive Director. Nurs	•	
		tooth pain. Administered			employees were re-educated	-	
		e) as ordered prn (as			assessing dental needs and		
	needed)"	as ordered prir (as		notification of physician,			
	needed)				responsible party, social serv	/ice	
	10/15/11				and nursing supervisor, by		
	10/15/11 at 3:26				Director of Nursing Services,		
	continuously c/o	of toothache			designee, by 12/20/11. The Interdisciplinary Team was		
	impaction"				re-educated on the Clinical		
					Meeting Guidelines as it rela	tes to	
	The resident con	nplained of tooth pain and			reviewing the 24 Hour Repor	t for	
	was given pain n	nedication on 10/16/11,			resident change of condition,	, ,	
	10/17/11, 10/18/11, and 10/19/11.				the Director of Nursing Servi	ces	
		, 			on 12/19/11. Staff were re-educated on the Care/Cor	noorn	
	10/20/11 at 2:42	P.M. "Dentist to			forms that may be utilized by		
		nd med. (medication)			residents and responsible pa		
	1	· /			to notify the facility of dental		
	• `	appointment) will be set.			concerns, by Social Service	or	
	Tylenol gr (grains) x (ten) x 1 given for				designee, by 12/20/11. Soc	ial	
	complaints of too	oth pain"			Service is responsible for	.	
					ensuring resident routine and	ן	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620					NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
				LDING		12/07/2011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				675 S FORD RD				
ZIONSVILLE MEADOWS				ZIONSV	/ILLE, IN46077			
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TAG	,			TAG	emergent dental needs are n	not	DATE	
	10/21/11 at 12:03 A.M. "Resident did				through review at the daily			
		pain which was relieved			Interdisciplinary meeting with			
	with pain medica	ition"			follow-up through the CQI			
	44/=/44				process. How will the			
		P.M. "Dentist called per			corrective action(s) be monitored to ensure the			
		n apt (appointment) and			deficient practice will not re	cur.		
		that Md (physician) has			i.e., what quality assurance			
		s (resident) history in			program will be put into pla			
	•	er aptApt for res.			A Dental Services CQI tool	will		
	requested 2nd op	inion (sic) this Friday."			be utilized weekly x 4, and			
		monthly x 2 and quarterly x 2, by Social Service/Nursing Managers						
	11/14/11 at 5:04 P.M. "Dentist office called to confirm with apt. this Wed. (Wednesday) and order noted to start				to monitor compliance with	igoro		
				physician notification. The audits will be reviewed by the CQI				
	_	pacted tooth Keflex 500			committee and action plans to be developed, if a threshold			
	mg, 1 cap tid x 7 days"			90% is not achieve, to improve compliance. Noncompliance with				
	The resident was	seen on 11/16/11 by an			facility policy and procedure			
		had three teeth extracted			result in employee education			
	with recommend				and/or disciplinary action up			
		tions in the future.			and including termination.			
	additional Cando	none in the rature.			Completion Date: 12/21/11			
	Interview on 12/	7/11 at 10:37 A.M. with						
	Unit Manager #1	indicated residents with						
	dental concerns of	other than routine						
	examinations sho	ould be "seen right away."						
	She indicated for referrals to outside							
	(other than facili	ty) dentists the Social						
		r contacted the outside						
	dentist and made	appointments. She						
	indicated staff sh							
		intments to assist with						
	transfers in the d							

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620		LDING	NSTRUCTION 00	(X3) DATE COMPI 12/07/2	LETED
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS			p. 1111	STREET A 675 S F	DDRESS, CITY, STATE, ZIP CODE ORD RD ILLE, IN46077	•	
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	the Social Services of appointments and in 1-2 days." He will accept Medi November 16, 20 available appoint being managed beindicated there were lated to dates a obtain dental appiliest made a phore. Interview on 12/the Administrator urgent dental con "within 7 days I" Review on 12/7/facility policy and provided by the identified as curres Services" indicate maintains an out dental services to resident"	7/11 at 11:45 A.M. with r indicated residents with accerns should be seen					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 12/07/2011			
NAME OF P	NDOVIDED OF CUIPNING			ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER		675 S F	ORD RD	
	LLE MEADOWS		ZIONS\	/ILLE, IN46077	
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